

178  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME  
5M 2/57

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**13652 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

13643  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head Md</b>		c. LENGTH OF STAY IN 1b <b>Unknown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <b>River Vtew Village Indian Head Md.</b>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Alfred Charles Clark</b>		First	Middle
4. DATE OF DEATH <b>12-31-58</b>	Month	Doy	Year <b>19</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White US</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <b>3-27-1912</b>	9. AGE (In years last birthday) <b>46</b> yrs.
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			10. CITIZEN OF WHAT COUNTRY? <b>USA</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Powder worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Govt.</b>	
11. BIRTHPLACE (State or foreign country) <b>Cherry Hill Va.</b>		12. FATHER'S NAME <b>Alfred W. Clark</b>	
13. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Bassie Love</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>718-16-9792</b>	
17. INFORMANT <b>Official Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Injuries Multiple Extreme</b>			
DUE TO <b>919.3</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Explosion</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Was working at the Naval Powder Factory Indian Head where there was an explosion killing him instantly</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Explosion at the Naval Powder Factory Indian Head Md</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>12-31-58</b> p. m. <b>27</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Factory</b>		20f. (City or town) <b>Indian Head Md.</b> (County) <b>Charles</b> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James E. Andrews MD</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>1-1-59</b>			
22e. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 3, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Patrick Cem.</b>		22d. LOCATION (City, town, or county) <b>Gobuck</b> (State) <b>Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Waldorf, Md.</i>		24e. REC'D BY REGISTRAR DATE <b>JAN 6 '59</b>	
ADDRESS <i>Arthur E. Hunt</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Hunt</i>	

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Page 50

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#### **REFERENCES**

1. "The King's Speech," directed by Tom Hooper

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#### REFERENCES

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HEALTH DEPT.



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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13645

## 13654 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>CHARLES</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rock Point</i>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rock Point</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>First J. Last Webster EDELEN</i>		4. DATE OF DEATH Month <i>12</i> Doy <i>23</i> Year <i>1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 30, 1913</i>
9. AGE (In years last birthday) <i>45 yrs.</i>		10. IF UNDER 16 YEARS Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Oysterman</i>	
11. BIRTHPLACE (State or foreign country) <i>Med</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Edward Edelen</i>		14. MOTHER'S MAIDEN NAME <i>Maggie Fuer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>229-16-8900</i>	
17. INFORMANT <i>Edward Edelen Post Point Md</i>		18. CAUSE OF DEATH [Enter only one cause per line] for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> DUE TO <i>Arterial hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension</i> DUE TO <i>1457</i> (c)	
INTERVAL BETWEEN ONSET AND DEATH <i>12-23-58</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Post Point</i> (County) <i>Charles</i> (State) <i>Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>E. J. Edelen</i>		DATE SIGNED <i>12-23-58</i>	
EXAMINER'S NAME (Type) <i>E. J. EDelen</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>12/26/58</i>	
22c. NAME OF CEMETERY OR CEMBRYATORY <i>Holy Ghost</i>		22d. LOCATION (City, town, or county) <i>Issue</i> (State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Lee Deplata Jr.</i>		ADDRESS <i>Arthur S. Kraus</i>	
		24a. REC'D BY REGISTRAR <i>DEC 29 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



FOR STATE  
HEALTH DEPT.

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V.S. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13655 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13646

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Md. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf
d. LENGTH OF STAY IN 1b Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Cecil P. GATES Middle Lost 4. DATE OF DEATH Month 12 - 26 Day Year 1958

5. SEX M 6. COLOR OR RACE Cau 7. MARRIED  NEVER MARRIED  8. DATE OF BIRTH JUNE 16, 1898 9. AGE (In years from birthday) 60 yrs. IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK 10b. KIND OF BUSINESS OR INDUSTRY Restaurant 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Benjamin F. Gates 14. MOTHER'S MAIDEN NAME Lillie M. Wedding Address Mrs. Helen Norris, Ardmore, Md.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 17. INFORMANT Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Cardiac Arrest INTERVAL BETWEEN ONSET AND DEATH 0  
DUE TO 420.0  
Conditions, if any, which gave rise to immediate cause (b) Massive Coronary artery Occlusion 0  
(a), stating the underlying cause last. DUE TO (c) Arteriosclerotic Heart Disease years  
(a) Arteriosclerotic Heart Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) 19. WAS AUTOPSY PERFORMED?  
YES  NO

20a. EXTERNAL CAUSE WAS PRIMARY  OR CONTRIBUTING  CAUSE OF DEATH. None 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) occurred while sitting and eating  
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)  
Hour 12-26 1958 While Not while of work of work at Bar Waldorf, Charles, Md.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL SIGNATURE V.B. Dettor DATE SIGNED  
EXAMINER'S NAME (Type) V.B. DETTOR 12-26-58

22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL 22d. LOCATION (City, town, or county) (State)  
Burial 12-29-58 St Louis Waldorf, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE  
The Hunt Funeral Home, Waldorf, Md. DEC 31 '58 Charles S. Hunt



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13642

## 13651 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

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1. PLACE OF DEATH a. COUNTY <b>Charles</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head Md</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>39-Mattingly Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>John M. Gray (Case # 6933)</b>		First	Middle	Last	4. DATE OF DEATH 3002 Month 12-17-58 Day Year 19
5. SEX <b>Male</b>		6. COLOR OR RACE <b>W-US</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <b>10-30-58</b>	8. AGE (In years from birthday) — yrs.	9. IF UNDER 1 YEAR Months <b>1</b> Days <b>47</b> Hours <b>1</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>USA-District of Columbia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Unknown-Welfare Baby</b>		14. MOTHER'S MAIDEN NAME <b>Unknown-Welfare Baby</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Frank Catrufo Jr-Welfare Home Owner</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		491X DUE TO <b>Broncho Pneumonia</b> INTERVAL BETWEEN ONSET AND DEATH 2-Hrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cold-Coryza</b>		3-Weeks			
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
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ACTUAL SIGNATURE <i>James E. Andrews</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12-17-58	
EXAMINER'S NAME (Type) <b>James E. Andrews MD</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 12-19-58</b> 22b. DATE THEREOF <b>12-19-58</b> 22c. NAME OF CEMETERY OR CREMATORIAL <b>St. Charles</b> 22d. LOCATION (City, town, or county) <b>Olwynnont Neck</b> (State) <b>MD</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ruford Lee Laplata</i>		ADDRESS <b>Arthur S. Thomas</b>		24a. REC'D BY REGISTRAR DEC 22 '58 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

WISCONSIN STATE INSURANCE COMMISSION - WELTNER

STATE OF  
WISCONSIN

8023 MEDICAL EXAMINER CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13656 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13647

**Reg. Dist. No.**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)				
Charles Maryland		a. STATE Maryland b. COUNTY Charles				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Winchester	25 Yes	Winchester, Md				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM?				
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First	Middle			
Julia (Dame) Jackson			Last			
4. DATE OF DEATH		Month	Day			
12-10-58		Year	19			
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
Female	N	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		63 yrs.	Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Housewife		None		Maryland		USA
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME				
John Matthews		Berkman				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address
No				NOBLE JACKSON (Husband)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Hernia/Heart Disease						
331X DUE TO Hypertension						
Conditions, if any, which gave rise to immediate cause (b) DUE TO Asthma						
DUE TO (c) Cystic Fibrosis						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
Malnutrition						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE James Andrews		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12-10-58		
22a. BURIAL, CREMATION, REINTERMENT (Specify) REINTERMENT		22b. DATE THEREOF 12-13-58		22c. NAME OF CEMETERY OR Crematory Zion Baptist Cemetery		22d. LOCATION (City, town, or county) Montgomery Blvd 913 Flannery Rd, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE Montgomery Blvd 913 Flannery Rd		ADDRESS Montgomery Blvd 913 Flannery Rd		24a. REC'D BY REGISTRAR DEC 17 '58		24b. REGISTRAR'S SIGNATURE Ollie G. Lee

200 - 2000 ft. above sea level.

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13648

## CERTIFICATE OF DEATH

13657

Reg. Dist. No.....

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10W

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY Brydens Road (If rural give location)
Charles Brydens Road	41 yrs	X	Charles Brydens Road
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	1
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>4. DATE (Month) OF DEATH</b>	
(First) Florence		(Middle) Margaret	
(Last) Jenkins		Dec. 31 1958	
<b>5. SEX</b> F	<b>6. COLOR OR RACE</b> W	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> Single	<b>8. DATE OF BIRTH</b> March 25, 1917
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) None		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) Brydens Road, Md.		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> Benedict D. Jenkins		<b>14. MOTHER'S MAIDEN NAME</b> Mary Eva Coomes	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) No		<b>16. SOCIAL SECURITY NO.</b>	
<b>17. INFORMANT &amp; ADDRESS</b> Benedict D. Jenkins, Brydens Road, Md.		<b>18. MEDICAL CERTIFICATION</b>	
<b>I</b> DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 416X IMMEDIATE CAUSE (A) Rheumatic Fever		INTERVAL BETWEEN ONSET AND DEATH 38 yrs	
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO			
(C)			
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arthritis deformans		24 yrs	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>	
<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		(County) (State)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.</b>			
<b>SIGNATURE</b> Frank G. Susan M.D. Indian Head, Md.			
<b>DATE SIGNED</b> 12-31-58			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> Burial		<b>DATE THEREOF</b> Jan 2 1959	
<b>NAME OF CEMETERY OR CREMATORIUM</b> St. Joseph Catholic		<b>LOCATION (City, town, or county)</b> Pomfret	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>	
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> Albertine La Plante		<b>ADDRESS</b>	
<b>DATE</b> Jan 5 1959		<b>DATE</b> Jan 5 1959	

ST. DOMINIC'S STATION TO THE TRAORE STATE CHAUVILLE

TRAORE STATION CENTRE

1965-1966

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 237 1750 ans

13649

13658

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wayside</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wayside</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Beatrice</b>		First	Middle	JUPITER	4. DATE OF DEATH Month December Doy 11 Year 1958
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>June 6, 1856</b>	9. AGE (In years last birthday) <b>2 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Chesco Ind.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Robert Lee Jupiter</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Wills</b>		Address <b>Robert Jupiter Wayside Ind.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>286.5</b>		16. SOCIAL SECURITY NO.		17. INFORMANT INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) <b>286.5</b>		Malnutrition			
DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. <b>(b)</b>					
DUE TO <b>(c)</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Russell S. Fisher</b>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>12/11/58</b>	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>13/13/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Shiloh M.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chasworth Lepeltner</b>		ADDRESS <b>1000 N. Charles St. Baltimore Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 18 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
VS. ATSM SM 2/57					

STATE OF SOUTH DAKOTA  
DEPARTMENT OF HEALTH - DIVISION OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF  
SOUTH DAKOTA

NAME OF DECEASED	SEX	AGE	DEATH DATE	TIME	PLACE	CAUSE OF DEATH	DIAGNOSIS	EXAMINER
JOHN J. HANNAH	M	50	APRIL 15, 1968	10:00 A.M.	HOSPITAL	HEART DISEASE	HEART DISEASE	DR. R. L. HANNAH
REASON FOR EXAMINATION								DEATH CERTIFICATE
EXAMINER'S SIGNATURE								DR. R. L. HANNAH

NAME OF DECEASED	SEX	AGE	DEATH DATE	TIME	PLACE	CAUSE OF DEATH	DIAGNOSIS	EXAMINER
JOHN J. HANNAH	M	50	APRIL 15, 1968	10:00 A.M.	HOSPITAL	HEART DISEASE	HEART DISEASE	DR. R. L. HANNAH
REASON FOR EXAMINATION								DEATH CERTIFICATE
EXAMINER'S SIGNATURE								DR. R. L. HANNAH

NAME OF DECEASED	SEX	AGE	DEATH DATE	TIME	PLACE	CAUSE OF DEATH	DIAGNOSIS	EXAMINER
JOHN J. HANNAH	M	50	APRIL 15, 1968	10:00 A.M.	HOSPITAL	HEART DISEASE	HEART DISEASE	DR. R. L. HANNAH
REASON FOR EXAMINATION								DEATH CERTIFICATE
EXAMINER'S SIGNATURE								DR. R. L. HANNAH

1 ✓

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE  
HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13659 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13650

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Charles		a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Mason Springs		x Indian Head	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
State Route # 225		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
Foy		Robinson	PENDERGRAFT
4. DATE OF DEATH		Month	Day
		DEC.	25
			1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> September 25, 1912
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days
46 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Retired - U.S. Government		Powder Factory	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
North Carolina		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Irvin Pendergraft		Ethel (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Yes 1930-1939		17. INFORMANT (Uncle) 15- Address Jonquil Place Mr. Henry L. Jansen Potomac Heights, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 825X DUE TO		1 min.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crush Injuries, Left Chest		1 min.	
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Highway Auto Accident	
20c. TIME OF INJURY Month, Day, Year Hour 8:35 p.m. 12-25-58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 20f. (City or town) (County) (State) Charles, Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE <i>V.B. Dettor</i> DATE SIGNED <i>12-25-58</i>	
EXAMINER'S NAME (Type) <i>V. B. DETTOR</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 30, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM Arlington Natl. Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arbhart Funeral Home, Inc.</i>		24a. REC'D BY REGISTRAR ADDRESS * LA PLATA, MD. DEC 29 '58	
AREHART FUNERAL HOME, INC. * LA PLATA, MD.		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knapp</i>	

MANUFACTURED STATE EXAMINER'S CERTIFICATE OF DEATH  
1902

STATE  
TENNESSEE

DECEASED PERSON'S NAME  
WILLIAM H. COOPER

ADDRESS  
100 W. 12TH ST., MEMPHIS, TENN.

NAME AND ADDRESS OF PERSON REPORTING  
JAMES COOPER, 100 W. 12TH ST., MEMPHIS, TENN.

TIME AND PLACE OF DEATH  
10:00 A.M., 12TH FLOOR, HOME OF JAMES COOPER, 100 W. 12TH ST., MEMPHIS, TENN.

CAUSE OF DEATH  
HEART DISEASE

AGE AT DEATH  
65 YEARS

SEX  
M

RACE  
WHITE

RELIGION  
METHODIST

EDUCATION  
SOME HIGH SCHOOL

EMPLOYMENT  
PUBLICATIONS

HOBBIES  
READING

EXTRA WORK  
NOT WORKING

DEATH  
REGISTRATION  
NUMBER  
1234567890

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**13660 CERTIFICATE OF DEATH**

**Reg. Dist. No**

13651

1. PLACE OF DEATH o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE	
Charles				Maryland Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
26 Phu Nell		3 Days		Baltimore Deced x	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Physicians Memorial Hospital					
3. NAME OF DECEASED (Type or print)		First Middle		4. DATE OF DEATH	
MINGONETTE POSEY		Last		12-29-58 Month Day Year	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Female		White		8. DATE OF BIRTH	
				4-6-1882	
9. AGE (In years b. birthday) yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.	
76					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		None		Charles Co Md	
12. CITIZEN OF WHAT COUNTRY?					
USA					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address	
Thomas Richard Ferrall		Sarah B.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		None		Leok. Ferrall Jr. La Plata, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		420.1 Coronary Thrombosis		31 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Hypertension		Infant	
{ DUE TO		(c) Cerebro-Sclerous - General		Infant	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from olive on 12-29-58, 19		to 12-29-58, 19		, that I last saw the deceased alive on 12-29-58, 19, and that death occurred at 5:45 P.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)		DATE SIGNED	
PHYSICIAN'S NAME (Type)		James E. Andrews M.D.		12-29-58	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL	
Burial		12/31/58		Cedar Hill	
22d. LOCATION (City, town, or county)				(State)	
				Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
The Hunt Funeral Home, Waldorf, Md.				24b. REGISTRAR'S SIGNATURE	
				Arthur S. Traut	

**O HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**O FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by [REDACTED] funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILHELM STADEGALLERIE - MELTS - AACHEN

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13661

## CERTIFICATE OF DEATH

13652

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Charles</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hughesville</i>		c. LENGTH OF STAY IN 1b <i>Life</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hughesville</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <i>Joseph</i>	Middle <i>Gilbert</i>	Last <i>ROBERTS</i>	4. DATE OF DEATH	Month <i>DEC</i>	Day <i>20</i>	Year <i>1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>Cau</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Aug 5, 1881</i>	9. AGE (In years lost birthday) <i>77 yrs.</i>	IF UNDER 1 YEAR Months <i></i>	IF UNDER 24 HRS. Days <i></i>	Hours <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Henry Roberts</i>		14. MOTHER'S MAIDEN NAME <i>Sarah</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs Gilbert Roberts, Hughesville, Md.</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		DUE TO <i>Coronary Thrombosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>INSTANT</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i></i>		(b) <i></i>						
DUE TO <i></i>		(c) <i></i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day at work	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County)	(State)	
21. I certify that I attended the deceased from <i>Dec 16, 1958</i> , to <i>Dec 20, 1958</i> , that I last saw the deceased alive on <i>Dec 16, 1958</i> , and that death occurred at <i>3095 M.</i> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>J. Roy Gwyther</i>	M.D.		ADDRESS (Street, city or town, state) <i>Mechanicsville, Md.</i>		DATE SIGNED <i>12/20/58</i>			
PHYSICIAN'S NAME (Type) <i>J. Roy Gwyther</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/23/58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>St Peters</i>	22d. LOCATION (City, town, or county) <i>Waldorf, Md.</i>	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Waldorf, Md.</i>	ADDRESS		24a. REC'D BY REGISTRAR <i></i>	24b. REGISTRAR'S SIGNATURE <i></i>				
VS A15 (4) 15M 9/55		DATE DEC 20 '58						

AT 380M IT IS 14:00Z 18 SEPTEMBER 2012

1

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 1 Film 240 - 4/2/59 a.m. MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1 4 4 4 1

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Occoquan Bay Virginia</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Indian Head</i>		c. LENGTH OF STAY IN 1b <i>20 yrs.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Washington D.C.</i>		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>142-12th St. S.E.</i>		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Hartley Hill Schenck</i>		First	Middle	Last	4. DATE OF DEATH <i>12-15-58</i>	Month	Doy	Year	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>W-US</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-31-92</i>	9. AGE (In years from birthday) <i>66</i>	yrs.	IF UNDER 1YEAR Months	IF UNDER 24 HRS. Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>		11. BIRTHPLACE (State or foreign country) <i>Fairfax County, Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>John Henry Schenck</i>		14. MOTHER'S MAIDEN NAME <i>Anna Hill</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>300-63-7616</i>		17. INFORMANT <i>Mrs Ida Schenck - Wife</i>		Address <i>142-12St SE. Wash-3D</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fatal Submersion</i>									
850X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <i>Accidental</i>							
DUE TO									
DUE TO									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Was on a boat that foundered</i>							
20c. TIME OF INJURY Hour <i>7-30 p.m.</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, <i>Occoquan office bldg., etc.</i> )		20f. (City or town) <i>Fairfax County Va.</i>		(County) <i>Fairfax County</i> (State) <i>Va.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>James E. Andrews</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <i>3-22-59</i>			
EXAMINER'S NAME (Type) <i>James E. Andrews</i>		22b. DATE THEREOF <i>3/23/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Cemetery</i>		22d. LOCATION (City, town, or county) <i>Suitland, Md.</i>		(State)	
22a. BURIAL / CREMATION, REMOVAL (Specify) <i>Cremation</i>		22d. REC'D BY REGISTRAR DATE <i>APR 2 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur J. Schenck</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Father John Schenck - 741-11th &amp; S.E.</i>		ADDRESS <i>R. A. Smith 728-2</i>							

WILDFIRE STATE DETERMINANT OF HAZARD - BATTALION 10  
MEDICAL EXTRICATION CERTIFICATE OF DEATH

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13662 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14427

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head, Md.		c. LENGTH OF STAY IN lb Unknown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Tobacco			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)		First Francis	Middle Austin	Last Thomas	4. DATE OF DEATH 12-31-58	Month Dec	Day 31	Year 1958
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9-20-20	9. AGE (In years last birthday) 38 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Powder Factory Worker	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME Unknown	Address		
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. US Army	17. INFORMANT Official Records			
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries Extreme</u> DUE TO <u>916.3</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Explosion</u> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II of Item 18.) Was working at the Naval Powder Factory Indian Head Md. Where there was an explosion killing him instantly				
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20c. TIME OF INJURY 12-31-58 11-21 a.m. p.m.	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Factory	20f. (City or town) Indian Head Md	(County)	(State)
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
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ACTUAL SIGNATURE <i>James E. Andrews MD</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7-1-59 Certified to be a true copy <i>James E. Andrews MD</i>
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22a. BURIAL, CREMATION, REMOVAL (Specify) 1/1/59	22b. DATE THEREOF 1/1/59	22c. NAME OF CEMETERY OR CREMATORIAL Beltop Md.	22d. LOCATION (City, town, or county) Beltop Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Johnson &amp; Jenkins</i>	ADDRESS 4804 Ga. Ave NW	24a. REC'D BY REGISTRAR DATE JAN 15 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

HTAEORO STADIUM 122-35114203 140-0917-0

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13653

13663

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>M.D.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		c. LENGTH OF STAY IN lb <i>1b</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Physicians Memorial</i>		e. STREET ADDRESS <i>x Waldorf - Rural</i>	
3. NAME OF DECEASED (Type or print) <i>James A. YATES</i>		First	Middle
4. DATE OF DEATH <i>12-24 1958</i>	Last	Month	Day
5. SEX <i>M</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>1886</i>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) <i>72 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>UNK</i>		14. MOTHER'S MAIDEN NAME <i>UNK</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Amanda Yates, Waldorf, Md.</i>		Address <i>Address</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Myocardial Infarction</i> DUE TO (c) <i>Generalized Arteriosclerosis</i> DUE TO INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>Benign Prostatic Hypertrophy with obstruction</i>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>No injury</i>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>no injury</i> 19 p. m. <i>no injury</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>La Plata, Charles, Md.</i>		20f. (City or town) (County) (State) <i>La Plata, Charles, Md.</i>	
21. I certify that I attended the deceased from <i>August 1957 to 12-24 1958</i> , that I last saw the deceased alive on <i>12-23 1958</i> , and that death occurred at <i>5:30 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>V. B. Dettor</i> PHYSICIAN'S NAME (Type) <i>V. B. DETTOR</i> ADDRESS (Street, city or town, state) <i>La Plata, Md.</i> DATE SIGNED <i>12-26-58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-29-58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>St Peters</i>		22d. LOCATION (City, town, or county) (State) <i>Waldorf, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Waldorf, Md.</i>		24a. REC'D BY REGISTRAR DATE DEC 31 '58	
		24b. REGISTRAR'S SIGNATURE <i>John E. Hunt</i>	

